

Shue

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041551

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 27

Primary Registration District No. 3005

Registrar's No. 223

FILED DEC 4 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

ITEM NO.

SHOULD READ

BY AFFIDAVIT OF

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1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Bates	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Butler		Length of stay in 1b 180 days	
c. CITY OR TOWN Butler RFD Rt 3		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bates Co Memorial Hosp.		d. STREET ADDRESS (If outside, give location) Butler RFD Rt 3	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANE ANN BOSWELL		4. DATE OF DEATH Month Nov. Day 27 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb 12/80
9. AGE (last birthday) 82		IF UNDER 1 YEAR Months 9 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Topsville Pa.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME J W Mitchell		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE W H Boswell (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Alice Smith Independence Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) hypertension		14 mo.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) congestive heart failure, 14 months.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Butler, Mo.	
20g. COUNTY Independence Mo.		20h. STATE Mo.	
21. I attended the deceased from Aug. 2nd, '62 to Nov. 27th '62 and last saw her/him alive on Nov. 27th '62 Death occurred at 7:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) L. S. Laffner, M.D.		22b. ADDRESS 212 N. Main St., Butler, Mo	
22c. DATE SIGNED Nov. 28 '62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/30/62	23c. NAME OF CEMETERY OR CREMATORY Mt Grove Cemetery	23d. LOCATION (City, town, or county) Independence Mo.
24. FUNERAL DIRECTOR Carson Funeral Home		25. DATE RECD. BY LOCAL REG. 11-28-62	
ADDRESS Missouri		26. REGISTRAR'S SIGNATURE Norma Jean Wilson	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John G. Underwood

Licensed Embalmer No. 3585

P. O. Address Bethel MD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.